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	50G053	A. BUILDING _____ B. WING _____	R-C 01/21/2020

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FIRCREST SCHOOL PAT A	**15230 15TH NORTHEAST D SEATTLE, WA 98155**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This report is the result of a Revisit Survey at Fircrest Residential Habilitation Center on 01/13/20, 01/14/20, 01/15/20, 01/16/20, 01/17/20, and 01/21/20. This survey was conducted by: Arika Brasier Linda Davis Gerald Heilinger Jim Tarr The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 Telephone: (360) 725-2484	{W 000}		
{W 104}	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to keep an accurate record of Clients' files when it did not ensure that Qualified Intellectual Disability Professionals (QIDP) filed the most recent QIDP Reviews in the Clients' charts for four of eight Sample Clients (Clients #2, #6, #7, and #8) and did not ensure a consent	{W 104}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{W 104}	Continued From page 1 was filed for one Expanded Sample Client (Client #11). This failure resulted in the facility not making all necessary corrections to previous citations to ensure compliance was achieved. This is a repeat citation from the Recertification Survey completed 10/11/19. Findings included ... QIDP Reviews not in Clients' files During an interview on 01/14/20 at 2:22PM, Staff A, Program Area Team Director, stated that QIDP Reviews should go into the Client's file at the end of every month. Client #2 Review of Client #2's file on 01/13/20 showed the most recent QIDP Review was dated 11/15/19. Client #6 Review of Client #6's file on 01/13/20 showed the most recent QIDP Review, undated, analyzed and reviewed information through November 2019.	{W 104}		

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{W 104}	Continued From page 2 Client #7 Review of Client #7's file on 01/13/20 showed the most recent QIDP Review was dated 10/15/19, and analyzed data through the end of September 2019. Client #8 Review of Client # 8's file showed the most recent QIDP Review was dated 10/14/19 and analyzed data through the end of September 2019. Consents not in Client's file Review of Client #11's file on 01/13/20 showed a consent for the use of adaptive dining equipment was missing from Client #11's file located at his House and used by staff. During an interview 01/15/20 at 9:14 AM, Staff D, QIDP stated that the Consent for the adaptive dining equipment was not in Client 11's file at the time the file was reviewed by the State Surveyor.	{W 104}		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.	W 137		

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W 137	Continued From page 3	W 137		

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to have a detailed record of personal possessions for one of eight Sample Client's (Client #4). This failure prevented the facility from being able to identify, account for, and safeguard all Clients' possessions.

Findings included ...

Record review of Client #4's Personal Inventory Sheet, dated 10/09/17, showed staff had hand written the following:
15 Underwear
20 Sock
17 Shirts
8 Long Sleeve
6 Pants
7 Short Pants
4 PJ
5 Jacket
8 Sweatshirt Jacket
4 Jeans
5 Sport Pants
1 Winter Gloves
4 Winter Hats
4 Pillows
8 Linens
2 Teddy Bear
3 Basketball

It did not give any details for the items.

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W 137	Continued From page 4 During an interview on 01/21/20, at 12:28 PM, Staff A, Program Area Team Director, stated that Client #4's Personal Inventory Sheet was not adequate and should give detailed descriptions for each item.	W 137		
{W 159}	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure their Qualified Intellectual Disability Professional (QIDP) provided oversight for three of eight Sample Clients' (Clients #5, #8, and #11) when Active Treatment Schedules were not updated or accurate. One Expanded Sample Client (Client #7) had discrepancies in his Individual Habilitation Plan (IHP) that were not reconciled. The lack of oversight by the QIDPs could result in Clients not receiving training to learn new skills. This is a repeat citation from the Recertification Survey completed 10/11/19. Findings included... Active Treatment Schedules not updated Client #5	{W 159}		

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{W 159}	Continued From page 5 Record review of Client #5's Active Treatment Schedule, dated 01/01/20, showed he had 10 formal training plans. The Active Treatment Schedule only identified time periods during the day for six of the 10 training plans. There were no time periods identified to implement his microwave program, wash cup program, applying deodorant program, and showering program. The Active Treatment Schedule for Client #5 didn't make any reference that he showered. During an interview on 01/17/20 at 10:40 AM, Staff E, Developmental Disability Administrator 1 (DDA 1) stated that the Active Treatment Schedules should include all the current formal training programs for Client #5. Client #8 Record review of Client #8's Active Treatment Schedule, dated 09/17/18, showed it had not been updated to reflect when to implement all the formal training programs identified in his 10/25/19 IHP. During an interview on 01/17/20 at 10:00 AM, Staff C, QIDP, and Staff E, DDA 1, stated that Client #8's Active Treatment Schedule needed to be updated. Client #11	{W 159}		

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{W 159}	Continued From page 6 Review of Client #11's file showed a training plan for a "Pack a Lunch" program to be implemented Monday, Tuesday, and Thursday during the morning shift. Record review of Client #11's Active Treatment Schedule, dated 01/06/20, showed there was no time identified for when staff were to implement his "Pack a Lunch" formal training program. During an interview on 01/15/20 at 9:14 AM, Staff D, QIDP, stated that he forgot to put Client #11's "Pack a Lunch" program onto the Active Treatment Schedule. IHP not reconciled Client #7 Record review of Client #7's IHP, dated 04/30/2019, showed: 1. On page one Special Instructions/ Alerts which listed "Diet-Regular with thin liquids. [Client #7's first name has no adaptive equipment]." 2. On page three Adaptive Equipment/Restrictive Devices which listed: "Dining Equipment-Lipped Plate: [Client #7's first name] uses a lipped plate to promote independence by enabling him to scoop his food". During an interview on 01/21/2020 at 11:30 AM, Staff P, QIDP, stated that Client #7 did not use	{W 159}		

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{W 159}	Continued From page 7 adaptive dining equipment and it was a discrepancy within the IHP.	{W 159}		
{W 214}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assess one Expanded Sample Client's (Client #10) consistent refusals to participate in his active treatment program. Client #10's refusals were identified in the Recertification Survey completed 10/11/19. This prevented the facility from understanding what contributed to the refusals and from developing the best program/s to meet the need. This is a repeat citation from Recertification Survey completed 10/11/19. Findings included ... Record review of Client #10's file showed no assessment of the problem of refusing to participate in his active treatment program. During an interview on 01/13/20 at 4:05 PM, Staff I, Speech Language Pathologist, stated that there was no comprehensive assessment of Client #10's refusing to participate in his active treatment program.	{W 214}		

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{W 227}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to write a program for an identified need for two of eight Sample Clients (Clients #3 and #7). Client #3 had a program to apply toothpaste to his toothbrush, when facility assessments said he was independent in brushing his teeth. Client #7 had programs for skills he was independent in, but no program for his refusals or lack of motivation to participate. This failure resulted in the facility developing programs for skills Clients' already possessed and not providing training in areas of refusals or lack of motivation. This is a repeat citation from the Recertification Survey completed 10/11/19. Findings included ... Client #3 Review of Client #3's Individual Habilitation Plan (IHP), dated 01/02/20, showed he had a training objective to apply toothpaste to his toothbrush or	{W 227}		

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{W 227}	Continued From page 9 soft cloth. Review of Client #3's Occupational Therapy Evaluation, dated 12/30/19, showed: "He is able to prepare toothbrush and manage oral care without assistance." Review of Client #3's Direct Care Independent Living Skills Assessment, dated 08/05/19, showed he was rated as "Independent" by all 3 shifts of Direct Care Staff for "Puts toothpaste on toothbrush." During an interview on 01/17/20 at 9:00 AM, Staff K, Developmental Disabilities Administrator 1, stated that Client #3 was not always motivated to clean his dentures and the program was written to help him with motivation to clean his dentures. She stated that Client #3 had the skill to apply toothpaste to a toothbrush. Client #7 Record review of Client #7's IHP, dated 04/30/19, showed the following: 1. "[Client #7's first name] is self-reliant when he washes his face and hands". 2. "He will independently turn on/off the water". 3. "He will independently make his bed". 4. "He independently identifies numbers/coins/bill and will match coins/bill".	{W 227}		

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{W 227}	Continued From page 10 Record review of Client #7's training programs for the month of January 2020 showed the following objectives: 1. "[Client #7's first name] will turn on the water (Step1) with verbal prompting for 60% of trials by February 29, 2020". 2. "[Client #7's first name] will remove the dirty sheet (step 4) with verbal prompting for 75% of trials for one month by February 29, 2020". 3. "[Client #7's first name] will separate change into different denominations with verbal and physical prompting 75% of trials for one month by February 29, 2020". During an interview on 01/21/20 at 11:30 AM, Staff O, QIDP, and Staff P, QIDP stated that Client #7 already had the skills stated in the objectives for his training programs but was not motivated or refused to do them. He did not have a programs written to address his refusal or lack of motivation.	{W 227}		
{W 234}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(i) Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that teaching plans contained clear and detailed instructions for staff to implement them correctly and consistently for three of eight Sample Clients (Clients #3, #5, and #7) and one Expanded Sample Client (Client #11). Client #3's one to one supervision guidelines were not clear. Client #5's teaching plan for washing his cup had the wrong	{W 234}		

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{W 234}	Continued From page 11 reinforcement. Client #7's instructions for removing a sheet were confusing. Client #11's training plan for eyeglass care identified the wrong training materials. This resulted in staff not really knowing how and what to teach the Clients. This is a repeat citation from the Recertification Survey completed 10/11/19. Findings included... Client #3 Record review of Client #3's Individual Habilitation Plan (IHP), dated 01/02/20, showed the following under the heading "Special Instructions / Alerts": "Supervision: [Client #3's first name] will be on a protective, restrictive supervision, 1:1 post from 6:30am-11pm. He can be on a shared post on the unit only. While off campus, [Client #3's first name] will be a 1:1, at arm's length." No other details about how the supervision should be implemented by staff were given. Record review of Client #3's PBSP (Positive Behavior Support Plan) Staff Instructions, dated 01/02/20, showed: "Supervision: [Client #3's first name] will be on a 1:1 on from 6:30 AM-11PM. When [Client #3's first name] is at the Adult Program he will be a shared. He can be a shared post on the unit only. While off campus, he will be a (1:1) at arm-length when he is off campus	{W 234}		

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{W 234}	Continued From page 12 (sic)." During an interview on 01/17/20 at 9:00 AM, Staff J, Psychologist, when asked about the contradictions and differences in the instructions, stated that she thought the instructions were clear. Client #5 Record review of Client #5's training program titled "Wash Cup" showed that after Client #5 had rinsed his cup and put it in the sanitizer the staff was to give the verbal reinforcement "Great job rinsing your cup [Client #5's first name]! Now you're ready to put cup into sanitizer." During an interview on 01/17/20, Staff E, Developmental Disability Administrator 1 stated that the verbal reinforcement for the Wash Cup training program was not updated. Client #7 Record review of Client #7's Bed Making teaching program showed an objective for Client #7 to remove the dirty sheet from his bed. It gave instructions for staff to provide a verbal prompt by saying, "[Client #7's first name], please remove the dirty sheet". The instructions for providing reinforcement showed: "When [Client#7's first name] gets a clean pillowcase from the linen	{W 234}		

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{W 234}	Continued From page 13 closet, provide verbal reinforcement saying "Great job, removing the dirty sheet, [Client #7's first name]." During an interview on 01/21/2020 at 11:30 AM, Staff O, Qualified Intellectual Disability Professional (QIDP), and Staff P, QIDP, stated that the program instructions for the reinforcement was confusing and had been made in error. Client #11 Record review of Client #11's training plan for "Glasses Care" showed the materials needed to implement the program were "2 Brooms, Dustpan." During an interview on 01/15/20 at 9:14 AM, Staff D, QIDP stated that the materials listed on Client #11's "Glasses Care" training program were incorrect.	{W 234}		
{W 239}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(vi) Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.	{W 239}		

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{W 239}	Continued From page 14 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to identify a replacement behavior for one of eight Sample Clients (Client #3). The facility changed the previous replacement behavior to a training program and did not identify a new replacement behavior and develop a program for it. This failure prevented Client #3 from receiving training on how to meet his needs in socially acceptable ways. This is a repeat citation from Recertification Survey completed 10/11/19. Findings included ... During an interview on 01/17/20 at 9:00 AM, Staff J, Psychologist, when asked about the replacement behavior for Client #3 related to deep breathing, stated that the program had been changed from a replacement behavior program to a training program. When asked what the new replacement behavior program was, she stated he did not currently have a replacement behavior program. Record review of the TEACHING PLAN and DATA SHEET for Client #3 related to deep breathing, handed to the surveyor during the interview on 01/17/20, showed it had a start date of 01/10/20 and was not labeled a replacement behavior.	{W 239}		

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{W 239}	Continued From page 15 Record review of Client #3's file on 01/13/20 showed a REPLACMENT BEHAVIOR TRAINING PLAN and DATA SHEET with a start date of 01/02/20 which identified an objective with deep breathing as the identified behavior. There were no other programs identified as a replacement behavior in Client #3's file.	{W 239}		
{W 250}	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to update Active Treatment Schedules to reflect current Individual Habilitation Plans (IHP) for three of eight Sample Clients (Clients #5, #6, and #8) and one Expanded Sample Client (Client #11). Client #6's Active Treatment Schedule was not updated to reflect his current prioritized needs. Clients #5, #6, #8, and #11's Active Treatment Schedules were not updated to reflect: the addition of new training programs; the discontinuation of training programs; or when those programs were to be implemented throughout the Clients' day. This prevented facility staff from knowing what, when, and where Clients' training plans were to be implemented. This is a repeat citation from the Recertification Survey completed 10/11/19.	{W 250}		

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{W 250}	Continued From page 16 Findings included ... Client #5 Record review of Client #5's Active Treatment Schedule, dated 01/01/20, showed he had 10 formal training plans. The Active Treatment Schedule only identified time periods during the day for six of the 10 training plans. There were no time periods identified to run his microwave program, wash cup program, applying deodorant program, and showering program. The Active Treatment Schedule for Client #5 didn't make any reference that he showered. During an interview on 01/17/20 at 10:40, Staff E, Developmental Disability Administrator 1 (DDA 1) stated that the Active Treatment Schedules should include all the current formal training programs for Client #5. Client #6 Prioritized needs: Review of Client #6's file showed an IHP, dated 09/25/19, with prioritized needs in the areas of improving his gross and fine motor skills, and increasing participation in his Activities of Daily Living (ADLs) using both hands. The Active Treatment Schedule, dated 04/12/19, did not	{W 250}		

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{W 250}	Continued From page 17 contain this current information. Training programs: Review of Client #6's IHP Revision, dated 12/30/19, showed current training programs for Shaving and Personal Privacy. The Active Treatment Schedule, dated 04/12/19, did not contain the current training programs for Personal Privacy or Shaving. Review of Client #6's QIDP Review, undated, with an IHP date, 09/25/19, showed the following training programs were discontinued: choose leisure activity; make bed; safeguard money; and self-medication. The Active Treatment Schedule, dated 04/12/19, showed these as active training programs. During an interview on 01/17/20 at 11:08 AM, Staff L, QIDP and Staff K, DDA 1, stated that Client #6's Active Treatment Schedule, dated 04/12/19, was not current. Client #8 Record review of Client #8's Active Treatment Schedule, dated 09/17/18, showed it had not been updated to reflect when to implement all the formal training programs identified in his 10/25/19 IHP.	{W 250}		

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{W 250}	Continued From page 18 During an interview on 01/17/20 at 10:00 AM, Staff C, QIDP, and Staff E, DDA 1, stated that Client #8's Active Treatment Schedule needed to be updated. Client #11 Review of Client #11's file showed a training plan for a "Pack a Lunch" program to be implemented Monday, Tuesday, and Thursday during the morning shift. Record review of Client #11's Active Treatment Schedule, dated 01/06/20, showed there was no time identified for when staff were to implement his "Pack a Lunch" formal training program. During an interview on 01/15/20 at 9:14 AM, Staff D, QIDP, stated that he forgot to put Client #8's "Pack a Lunch" onto the Active Treatment Schedule.	{W 250}		
{W 251}	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.	{W 251}		

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{W 251}	Continued From page 19 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to implement training program plans as written for two of eight Sample Clients (Clients #5 and Client #7). Staff did not implement the required standby assistance when Client #5 walked outdoors and Client #7's navigation program was not implemented when he left the house. This failure placed Client #5 at risk for falling while walking outdoors and Client #7 at risk for not being safe when he traveled outside his residence. This is a repeat citation from the Recertification Survey completed 10/11/19. Findings included... Client #5 Record review of Client #5's Individual Habilitation Plan (IHP), dated 04/24/19, showed in the Section titled Special Instructions/Alerts, "Standby assistance when walking outdoors." In another section of the IHP titled Safety Awareness it was again stated that Client #5 required standby assistance when walking outdoors. Record review of Clint #5's Physical Therapy Evaluation, dated 01/02/20, showed "His gait pattern has not changed since last assessment. He ambulates with his head forward... [Client #5's first name] does not always pay attention to	{W 251}		

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{W 251}	Continued From page 20 surroundings when he walks and is easily distracted that can lead to falls, In order to prevent falls, [Client #5's first name] should ambulate outside with standby assistance of one staff. Staff should walk on the curbside of [Client #5's first name]." Observation on 01/14/20 at 11:37 AM showed Client #5 walking from the Adult Training Building with an Adult Training Specialist (ATS) staff who pushed another Client in a wheelchair. Client #5 walked several feet in front of the ATS. The ATS asked Client #5 to wait at the crosswalk and instructed him to look to his left and wright. After Client #5 crossed the street he walked approximately 10 feet in front of the ATS to the entrance of the coffee shop. The ATS instructed Client #5 to look where he was walking but did not ask him to wait until she caught up to him. During an interview on 01/15/20 at 9:47 AM, Staff F, Attendant Counselor Manager, stated that Client #5 needed stand by assistance when walking outside. He stated that staff should always be right next to Client #5 so they can reach out to him if needed. During an interview on 01/15/20 at 10:34 AM, Staff G, Physical Therapist, stated that Client #5 needed stand by assistance when walking outside. She stated that staff should be within arm's reach and walk between the curb and Client #5.	{W 251}		

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{W 251}	Continued From page 21 Client #7 Navigating Campus Safely Record review of Client #7's IHP, dated 04/30/18, showed a primary need of "Campus Safety: Staff will continue to encourage [Client #7's first name] to practice safe transitioning and mobility around the campus by emphasizing formal and informal training opportunities regarding traffic safety and general safety such as using grab bars and observing hazards signs." Review of Client #7's file on 01/13/20 showed a formal training plan titled "Safely Navigating Campus, with the objective of, [Client #7's first name] will avoid uneven surfaces of the sidewalk when navigating campus." It gave instructions for staff to approach Client #7 when he was leaving the House and provided the following verbal prompt: "Try to avoid uneven surfaces of the sidewalk to safely navigate campus [Client #7's first name]." Observation on 01/15/2020 at 10:24 AM at 320 House showed Client #7 exited the House with Direct Care Staff (DCS) to go to the 500 Building. The DCS did not implement his Safely Navigating Campus program nor did they caution him to stop at the crosswalk, or to look both ways. Observation on 01/15/2020 at 11:30 AM showed Client #7 exited the Art Room at the 500 Building with his DCS and traveled to the Coffee Shop. The DCS working with him did not implement his Safely Navigating Campus program nor did they	{W 251}		

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{W 251}	Continued From page 22 caution him to stop at the crosswalk, or to look both ways. During an interview on 01/21/2020 at 11:30 AM, Staff O, QIDP, and Staff P, QIDP, stated that Client #7's Safely Navigating Campus program should be implemented at every opportunity and that informal teaching of traffic safety should also have occurred.	{W 251}		
{W 252}	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff documented data and/or comments to show they implemented programs or explained why a program was not implemented for three of eight Sample Clients (Clients #2, #5, and #8). Staff did not collect data for a skill acquisition programs as required for Clients #2 and #5, and did not record a comment when a program was not implemented for Client #8. This prevented the facility from correctly analyzing the programs to determine if the facility needed to update or revise the programs to meet Clients' needs. This is a repeat citation from the Recertification Survey completed 10/11/19.	{W 252}		

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{W 252}	Continued From page 23 Findings included ... Client #2 Record review of Client #2's training programs showed missing data for one of his programs in January 2020. The Privacy program showed data was to be collected daily on the AM shift. Data was missing for the 13th. During an interview on 01/16/20 at 4:14 PM, Staff M, Qualified Intellectual Disability Professional (QIDP), stated that data was missing for Client #2's training program. Client #5 Record review of Client #5's training program for "Showering Plan" showed data was to be collected daily. A review of the section where data was to be recorded was the handwritten statement "Sheet on floor missing" and a line was drawn from 01/01/20 through 1/10/20. During an interview on 01/17/20 at 10:40 AM, Staff B, QIDP, stated that there was no data for Client #5's "Showering Plan" training program for 01/01/20 thru 01/10/20. Client #8	{W 252}		

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{W 252}	Continued From page 24 Record review of Client #8's training program for "Independence" showed data was to be collected on Monday, Wednesday, and Friday. If the training program was not implemented, staff were to record "NR" on the data sheet and write in the comment section why it wasn't implemented. "NR" was listed for 01/01/20, 01/03/20, and 01/10/20. There were no comments written as to why the program wasn't implemented on those three days. During an interview on 01/17/20 at 10:00 AM, Staff C, QIDP, stated that staff should have documented why the "Independence" program was not implemented on 01/01/20, 01/03/20, and 01/10/20.	{W 252}		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure an annual dental assessment occurred for one of eight Sample Clients (Client #4). This failure put Client #4 at risk for unidentified dental concerns. Findings included ...	W 352		

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W 352	Continued From page 25 Record review of Client #4's file on 01/14/20 showed an Annual Dental Assessment dated 09/10/18. During an interview on 01/14/20 at 10:47 AM, Staff N, QIDP, stated that the Annual Dental Assessment in Client #4's file was the most current.	W 352		
{W 407}	CLIENT LIVING ENVIRONMENT CFR(s): 483.470(a)(1) The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assess and document the benefit of one Expanded Sample Client (Client #9), identified during the Recertification Survey completed 10/11/19, living with Clients that did not match his developmental and social abilities. This failure caused Client #9 to remain living with peers who had significantly different skills and abilities from his without justification by the facility. This is a repeat citation from Recertification Survey completed 10/11/19. Findings included ...	{W 407}		

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{W 407}	Continued From page 26 Record review of Client #9's Individual Habilitation Plan (IHP), dated 11/06/19, showed there still was no assessment by the facility regarding why Client #9 continued to live in the house he did. The IHP showed Client #9 had not changed living residences since 10/11/19. During an interview on 01/13/20 at 11:45 AM, Staff A, Program Area Team Director, stated that there was no assessment by the facility for why Client #9 lived where he did.	{W 407}		
{W 474}	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide the correct diet texture to one of eight Sample Clients (Client #2). Client #2 received a snack that was not in the Dysphagia Advanced (food cut into pieces no larger than ½ inch, and no dry, hard, or crunchy foods) texture as prescribed in his diet orders. This endangered Client #2's health and safety; such as choking or aspiration (when food or saliva enters the airway and lungs). This is a repeat citation from the Recertification Survey completed 10/11/19.	{W 474}		

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{W 474}	Continued From page 27 Findings included ... Record review of Client #2's Diet Orders, dated 09/25/18, and Comprehensive Nutrition Assessment, dated 01/10/20, showed Client #2 was prescribed a Dysphagia Advanced diet texture for all meals. Observation on 01/14/20 at 3:40 PM at 303 House showed Client #2 received a snack of what appeared to be a pepperoni stick that was approximately three inches in length by approximately ½ inches round. During an interview on 01/16/20 at 4:10 PM, Staff M, Qualified Intellectual Disability Professional, and Staff H, Speech Language Pathologist, stated that Client #2's diet texture was Dysphagia Advanced and the pepperoni stick given to Client #2 was not within his diet texture.	{W 474}		

Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
FIRCREST RESIDENTIAL HABILITATION CENTER (RHC)

Plan of Correction

DATE OF SOD
01/21/2020
DATE OF POC
02/05/2020

CITATION

Citation: W104 Governing Body-QIDP Reviews

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to keep an accurate record of Clients' files when it did not ensure that Qualified Intellectual Disability Professionals (QIDP) filed the most recent QIDP Reviews in the Clients' files for four of eight Sample Clients (Clients #2, #6, #7, and #8) and did not ensure a consent was filed for one Expanded Sample Client (Client #11). This failure resulted in the facility not making all necessary corrections to previous citations to ensure compliance was achieved.

Facility Analysis of the Processes that led to the Deficiency:

- The expectation for filing the Qualified Intellectual Disabilities Professional Reviews in the Client file is by the 15th of every month. Due to a high turnover of Habilitation Plan Administrators there was not a clear understanding of the expectation for filing the Qualified Intellectual Disabilities Professional Reviews.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is January 14, 2020.

Immediate Actions:

- When the surveyors mentioned to the Program Area Director that the most recent Qualified Intellectual Disabilities Professional Reviews were not in the Sampled Clients files, the Program Area Director immediately notified the appropriate Habilitation Plan Administrators. The Habilitation Plan Administrators printed the already completed Qualified Intellectual Disabilities Professional Reviews and brought them to the Client Files within thirty minutes on January 14, 2020.
- The Developmental Disabilities Administrator sent an e-mail to the Habilitation Plan Administrators to print and file all current Qualified Intellectual Disabilities Professional Reviews and placed them in Client files.

STEPS FOR POC:

1. The Developmental Disabilities Administrators completed an in-service with the Habilitation Plan Administrators regarding the expectations for filing documentation which included but was not limited to Qualified Intellectual Disabilities Professional Reviews being filed in all Clients physical files by the 15th of every month.
    - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
    - Completion Date: February 7, 2020

Monitoring Procedure for Implementing the POC:

Superintendent
Signature / Title

2/21/2020
Date

1. For the next three months the Developmental Disabilities Administrators will choose a random sample from their caseload to verify that the Qualified Intellectual Disabilities Professional Reviews are in the physical Client file.
    - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
2. The Quality Assurance Department will do a quarterly sample of Qualified Intellectual Disabilities Professional Reviews to ensure that the Qualified Intellectual Disabilities Professional Reviews are in the physical Client file.
    - Person Responsible: Quality Assurance Director

Signature / Title

Date

Washington State Department of Social & Health Services
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DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
FIRCREST RESIDENTIAL HABILITATION CENTER (RHC)

Plan of Correction

DATE OF SOD
01/21/2020
DATE OF POC
02/05/2020

CITATION

Citation: W104 Governing Body-Consent

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to keep an accurate record of Clients' files when it did not ensure that Qualified Intellectual Disability Professionals (QIDP) filed the most recent QIDP Reviews in the Clients' charts for four of eight Sample Clients (Clients #2, #6, #7, and #8) and did not ensure a consent was filed for one Expanded Sample Client (Client #11). This failure resulted in the facility not making all necessary corrections to previous citations to ensure compliance was achieved.

Facility Analysis of the Processes that led to the Deficiency:

- Client #11's adaptive dining equipment consent was sent through Human Rights Committee on 11/14/19. The Human Rights Committee approved the updated consent. The consent was then placed in the Habilitation Plan Administrator's mailbox to be filed. The consent was never placed in Client #11's file because the Habilitation Plan Administrator misplaced the consent and then forgot to follow up. The root cause is human error.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is January 15, 2020.

Immediate Actions:

- The consent was placed in the chart on January 15, 2020 following notification from the surveyor that it was not in the chart.

STEPS FOR POC:

1. The Developmental Disabilities Administrators completed an in-service with the Habilitation Plan Administrators regarding the expectations for filing documentation which included but was not limited to consents being filed in the all Clients physical files within three business days of obtaining due process.
    - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
    - Completion Date: February 7, 2020
2. Using the Individual Habilitation Plan Consent Tracker all Client files will be reviewed to ensure consents that have due process are in the physical Client file. The results of the review will be sent to the appropriate Habilitation Plan Administrator. If consents are missing, the Habilitation Plan Administrator will file it.
    - Person Responsible: Program Area Director
    - Completion Date: February 28, 2020

Monitoring Procedure for Implementing the POC:

Superintendent
Signature / Title

2/21/2020
Date

1. Following the Human Rights Committee meeting, the Quality Assurance Department will be completing file reviews to ensure that all consents have been filed. The results of the review will be sent to the Program Area Director and Developmental Disabilities Administrators for any appropriate follow up.
    - Person Responsible: Quality Assurance Director

Signature / Title

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DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
FIRCREST RESIDENTIAL HABILITATION CENTER (RHC)

Plan of Correction

DATE OF SOD
01/21/2020
DATE OF POC
02/05/2020

CITATION

Citation: W137 Protection of Client Rights

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to have a detailed record of personal possessions for one of eight Sample Clients (Client #4). This failure prevented the facility from being able to identify, account for, and safeguard all Clients' possessions.

Facility Analysis of the Processes that led to the Deficiency:

- The Developmental Disabilities Administration Client Inventory Standard Operating Procedure was not specific in regards to information required for item descriptions; therefore, staff were not trained to provide enough information.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is January 21, 2020.

Immediate Actions:

- The Program Area Director contacted the Residential Habilitation Center Program Manager to request that the Developmental Disabilities Administration Client Inventory Standard Operating Procedure be updated to include directions to staff for thoroughness of item descriptions.

STEPS FOR POC:

1. The Developmental Disabilities Administration Client Inventory Standard Operating Procedure will be updated to include directions to staff for thoroughness of item descriptions.
    - Person Responsible: Program Area Director
    - Completion Date: February 14, 2020
2. The Program Area Director will in-service the Attendant Counselor Managers on the updated Developmental Disabilities Administration Client Inventory Standard Operating Procedure. The in-service will include the facility expectation that Client Inventory tracking sheets will be reviewed at minimum annually and a copy be turned into the Habilitation Plan Administrator.
    - Person Responsible: Program Area Director
    - Completion Date: February 21, 2020
3. The Attendant Counselor Managers will in-service the Direct Care Staff for their unit on the updated Developmental Disabilities Administration Client Inventory Standard Operating Procedure.
    - Person Responsible: Attendant Counselor Managers with oversight by the Program Area Director
    - Completion Date: March 6, 2020
4. All Client inventory tracking sheets will be scanned and reviewed for thoroughness of item description by the Program Area Director and Quality Assurance Director. If descriptions are incomplete then the

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Attendant Counselor Managers will ensure a new a client inventory tracking sheet is completed and filed.

- Person Responsible: Attendant Counselor Managers with oversight by the Program Area Director
- Completion Date: March 20, 2020

5. The Habilitation Plan Administrators will be in-serviced on the updated Developmental Disabilities Administration Client Inventory Standard Operating Procedure. This will include the expectation of turning in the client inventory tracking sheet with annual programs to the Developmental Disabilities Administrator for review.
   - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
   - Completion Date: March 6, 2020
6. The program review form will be updated by the Developmental Disabilities Administrators to include the Client Inventory tracking sheet.
   - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
   - Completion Date: March 6, 2020

Monitoring Procedure for Implementing the POC:

1. The Developmental Disabilities Administrators will review the Client Inventory tracking sheet annually.
   - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

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Plan of Correction

DATE OF SOD
01/21/2020
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02/05/2020

CITATION

Citation: W159 QIDP-Active Treatment Schedules

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure their Qualified Intellectual Disability Professional (QIDP) provided oversight for three of eight Sample Clients (Clients #5, #8, and #11) when Active Treatment Schedules were not updated or accurate. One Expanded Sample Client (Client # 7) had discrepancies in his Individual Habilitation Plan (IHP) that were not reconciled. The lack of oversight by the QIDPs could result in Clients not receiving training to learn new skills.

Facility Analysis of the Processes that led to the Deficiency:

- While the facility was working on their plan to address the system for Active Treatment, there was significant fluctuation in Habilitation Plan Administrators. Three new Habilitation Plan Administrators were hired in October, one seasoned Habilitation Plan Administrator went out on unanticipated approved leave, one of the newly hired Habilitation Plan Administrators left at the end of November, and two new Habilitation Plan Administrators were hired on December 9, 2019. The Developmental Disabilities Administrators were covering caseloads for multiple units while training new Habilitation Plan Administrators. A new template for the Active Treatment Schedule was being developed in order to increase its' efficacy. The facility was under the impression that there would have been more time to finalize, implement, and train the on the new template prior to resurvey; however, due to an unexpected change in the survey timeline the entire process was not completed and some Active Treatment Schedules were not updated.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is January 27, 2020.

Immediate Actions:

- The new Active Treatment Schedule template was reviewed by the Program Area Director and Habilitation Plan Administrators were directed to update Active Treatment Schedules using the new template.

STEPS FOR POC:

1. The Habilitation Plan Administrators were be in-serviced on the content that must be included in the Active Treatment Schedules.
    - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
    - Completion Date: February 10, 2020

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2. The Habilitation Plan Administrators will update all Active Treatment Schedules using the new template as they are updated they will send them to their respective supervisor along with a list of all formal programs to be cross checked that all programs have been included in the schedule.
    - Person Responsible: Developmental Disabilities administrators with oversight by the Program Area Director
    - Completion Date: March 6, 2020
3. The Attendant Counselor Managers will be in-serviced on the new Active Treatment Schedule template.
    - Person Responsible: Program Area Director
    - Completion Date: February 19, 2020
4. The Habilitation Plan Administrator and Attendant Counselor Managers will in-service the Direct Care Staff on the updated Active Treatment Schedules as they are completed and prior to being implemented.
    - Person Responsible: Program Area Director
    - Completion Date: March 20, 2020
5. The Adult Training Specialists will be in-serviced on the updated Active Treatment Schedules as they are completed and prior to being implemented.
    - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
    - Completion Date: March 20, 2020
6. The Habilitation Plan Administrators will be in-serviced to include the Active Treatment Schedule with the Individual Habilitation Plan packet for review prior to implementation.
    - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
    - Completion Date: March 6, 2020

Monitoring Procedure for Implementing the POC:

1. The Developmental Disabilities Administrator will review the Active Treatment Schedule annually with the Individual Habilitation Plan program review.
    - Person Responsible: Program Area Director

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Plan of Correction

DATE OF SOD
01/21/2020
DATE OF POC
02/05/2020

CITATION

Citation: W159 QIDP-Individual Habilitation Plan Discrepancies

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure their Qualified Intellectual Disability Professional (QIDP) provided oversight for three of eight Sample Clients (Clients #5, #8, and #11) when Active Treatment Schedules were not updated or accurate. One Expanded Sample Client (Client # 7) had discrepancies in his Individual Habilitation Plan (IHP) that were not reconciled. The lack of oversight by the QIDPs could result in Clients not receiving training to learn new skills.

Facility Analysis of the Processes that led to the Deficiency:

- The discrepancy in Client #7's program surrounding the adaptive equipment was unidentified through the program review process. Client #7 was assessed for adaptive dining equipment and did have it in place in his 2018 Individual Habilitation Plan but according to Client #7's OT assessment in 2018 he did not require the use of adaptive equipment. This discrepancy was carried over from a previous program and although it was removed from the diet portion of the Individual Habilitation Plan it was not from the adaptive equipment section. During this time there were three different Habilitation Plan Administrators that had Client #7's caseload. In April 2019, the Developmental Disabilities Administrator that was performing the program reviews did not catch the error. Since then that Developmental Disabilities Administrator has been transferred to a position that is more suited to her skill set.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is January 17, 2020.

Immediate Actions:

- An Individual Habilitation Plan revision was completed to remove the adaptive equipment from Client #7's program on January 17, 2020.

STEPS FOR POC:

1. All adaptive equipment sections of the Individual Habilitation Plans will be reviewed to ensure what is included is current for the individual.
    - Person Responsible: Habilitation Plan Administrators
    - Completion Date: March 6, 2020
2. Following the review, if there are discrepancies in the adaptive equipment sections of the Individual Habilitation Plan an Individual Habilitation Plan Revision will be completed to correct the discrepancy.
    - Person Responsible: Habilitation Plan Administrators
    - Completion Date: March 13, 2020
3. All Individual Habilitation Plans will be reviewed to ensure that there are no discrepancies.

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- Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
- Completion Date: March 20, 2020

4. If there are discrepancies identified in the Individual Habilitation Plan, an Individual Habilitation Plan Revision will be completed to correct the discrepancy.
   - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
   - Completion Date: March 20, 2020

Monitoring Procedure for Implementing the POC:

1. The Developmental Disabilities Administrators will review the adaptive equipment portion along with diet portion of the Individual Habilitation Plan while doing program reviews and prior to due process.
   - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

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Plan of Correction

DATE OF SOD
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CITATION

Citation: W214 Individual Program Plan

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to assess one Expanded Sample Client's (Client #10) consistent refusals to participate in his active treatment program. Client #10's refusals were identified in the Recertification Survey completed 10/11/19. This prevented the facility from understanding what contributed to the refusals and from developing the best programs to meet the need.

Facility Analysis of the Processes that led to the Deficiency:

- Client #10 moved to a different unit on 12/18/19 and the Interdisciplinary Team was actively performing assessments for the anticipated Individual Habilitation Plan meeting which was held on 01/29/20. Those new assessments were not yet finalized during survey and not yet included in the plan to address his refusals for Active Treatment. The statement of deficiency referenced an interview with the Speech-Language Pathologist; however, during survey, Residential Care Services also interviewed the previous Habilitation Plan Administrator. During that interview the Habilitation Plan Administrator confirmed that the move impacted the timeline for including plans to address the refusals.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is January 29, 2020.

Immediate Actions:

- The Program Area Director interviewed the current Interdisciplinary Team. The current Interdisciplinary Team confirmed that they were actively working on the assessments so that they could get to know their new Client and implement appropriate strategies to increase his participation in Active Treatment.

STEPS FOR POC:

1. The Individual Habilitation Plan meeting was held on 01/29/20 for Client #10. The meeting included discussion of new assessments and a plan to address his refusals to Active Treatment.
    - Person Responsible: Habilitation Plan Administrator
    - Completion Date: January 29, 2020
2. The new Individual Habilitation Plan will undergo a full program review, due process, and Direct Care Staff will be in-serviced on the new program prior to implementation.
    - Person Responsible: Program Area Director
    - Completion Date: February 21, 2020
3. The previously gathered list of Clients that were identified for high refusal rates will be reviewed with the corresponding assessments and plans to ensure the refusals are addressed within the programming.

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- Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
- Completion Date: March 6, 2020

4. If an assessment and plan has not been completed, the Interdisciplinary Team will complete them and turn them in to the Developmental Disabilities Administrators for review. An Individual Habilitation Plan Revision and corresponding in-service will be completed prior to implementation.
   - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
   - Completion Date: March 20, 2020

Monitoring Procedure for Implementing the POC:

1. During the program reviews, the Developmental Disabilities Administrators will review identified barriers such as but not limited refusals and the corresponding assessments to ensure that there is a plan in place to address the identified barrier.
   - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

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DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
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Plan of Correction

DATE OF SOD
01/21/2020
DATE OF POC
02/05/2020

CITATION

Citation: W227 Individual Program Plan

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to write a program for an identified need for two of eight Sample Clients (Client #3 and #7). Client #3 had a program to apply toothpaste to his toothbrush, when facility assessments said he was independent in brushing his teeth. Client #7 had programs for skills he was independent in, but no program for his refusals or lack of motivation to participate. This failure resulted in the facility developing programs for skills Clients' already possessed and not providing training in areas of refusals or lack of motivation.

Facility Analysis of the Processes that led to the Deficiency:

- It is evident that while talking with the respective teams for Client #3 and Client #7 that they understand their Clients' needs. It is also evident that there is an unclear understanding in regards to how to write a plan to address motivation versus skill acquisition. The cited program skills are important "for" the Client to accomplish, however they are not necessarily important "to" the Client. The Client's Individual Habilitation Plan and corresponding assessments do not clearly identify the need as being motivation.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is February 7, 2020.

Immediate Actions:

- The Developmental Disabilities Administrators began working with Client #3 and Client #7's Habilitation Plan Administrators' to update the programs to focus on motivation rather than skill acquisition in their program as to address the identified barrier.

STEPS FOR POC:

1. All formal teaching plans and corresponding assessments will be reviewed to ensure the skill is not already known by the Client.
    - Person Responsible: Developmental Disabilities Administrator with oversight by the Program Area Director
    - Completion Date: March 6, 2020
2. If formal teaching plans are identified as being skills already known then new plans will be developed to address the identified need. Individual Habilitation Plan revisions and in-services will be completed prior to implementation.
    - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
    - Completion Date: March 13, 2020

Monitoring Procedure for Implementing the POC:

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1. During the annual program review, the Developmental Disabilities Administrator will cross check the objectives with the appropriate assessment to ensure formal teaching plans are written to properly address the identified need.
    - Person Responsible: Developmental Disabilities Administrator

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Plan of Correction

DATE OF SOD
01/21/2020
DATE OF POC
02/05/2020

CITATION

Citation: W234 Individual Program Plan-Client #3

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to ensure that teaching plans contained clear and detailed instructions for staff to implement them correctly and consistently for three of eight Sample Clients (Clients #3, #5, and #7) and one Expanded Sample Client (Client #11). Client #3's one to one supervision guidelines were not clear. Client #5's teaching plan for washing his cup had the wrong reinforcement. Client #7's instructions for removing a sheet were confusing. Client #11's training plan for eyeglasses care identified the wrong training materials. This resulted in staff not really knowing how and what to teach the Clients.

Facility Analysis of the Processes that led to the Deficiency:

- During survey, Client #3 was not feeling well therefore did not leave his residence. Residential Care Services did not have an opportunity to observe Client #3's supervision levels implemented by staff. During the interview conducted by Residential Care Services the Interdisciplinary Team asked if incorrect supervision implementation was observed and Residential Care Services confirmed it had not been observed to be wrongfully implemented. Although there were no concerns with the actual implementation of Client #3's supervision levels when supervision levels are updated information is added rather than redone which could give the written appearance to be disjointed. Sentences are used in the instructions when bullet points could provide more clarity.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is January 17, 2020.

Immediate Actions:

- Program Area Director interviewed staff from Client #3's unit and all were able to articulate supervision levels correctly.
- Observations were completed that showed correct implementation of supervision levels for Client #3 by the Direct Care Staff.
- The facility does not agree that Direct Care Staff were unclear on Client #3's supervision levels.

STEPS FOR POC:

1. All Protective Restrictive Supervision consents and Positive Behavior Support Plans will be gathered for review to ensure that the written instructions are clear to anyone either implementing or not implementing the plan.
    - Person Responsible: Program Area Director
    - Completion Date: March 5, 2020

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2. If any of the Positive Behavior Support Plans have unclear Protective Restrictive Supervision guidelines they will be updated to be clear. There will be a correlating Positive Behavior Support Plan Addendum and Individual Habilitation Plan Revision to address the updated supervision guidelines.
    - Person Responsible: Program Area Director
    - Completion Date: March 20, 2020
3. If there are changes to the supervision guidelines based on the review then an in-service will be completed by the unit Psychologist.
    - Person Responsible: Psychologists with oversight by the Program Area Director
    - Completion Date: March 20, 2020

Monitoring Procedure for Implementing the POC:

1. During the Clinical Review of the Positive Behavior Support Plans the Protective Restrictive Supervision guidelines will be reviewed to ensure clarity for implementation.
    - Person Responsible: Lead Psychologist
2. During the program reviews, the Developmental Disabilities Administrators will review the Protective Restrictive supervision guidelines to ensure clarity for implementation.
    - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

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Plan of Correction

DATE OF SOD
01/21/2020
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CITATION

Citation: W234 Individual Program Plan-Clients #5, 7, and 11

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to ensure that teaching plans contained clear and detailed instructions for staff to implement them correctly and consistently for three of eight Sample Clients (Clients #3, #5, and #7) and one Expanded Sample Client (Client #11). Client #3's one to one supervision guidelines were not clear. Client #5's teaching plan for washing his cup had the wrong reinforcement. Client #7's instructions for removing a sheet were confusing. Client #11's training plan for eyeglasses care identified the wrong training materials. This resulted in staff not really knowing how and what to teach the Clients.

Facility Analysis of the Processes that led to the Deficiency:

- The Habilitation Plan Administrators that were responsible for these programs had made modifications, such as moving on the next step in the task breakdown, to the programs and missed areas that should have been updated at the same time such as the materials and the verbal reinforcements. The issues were immediately updated by the responsible Habilitation Plan Administrator upon identification from the surveyors. Although these programs contained errors it did not affect the implementation of the programs and staff did not appear to be confused by the errors.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is January 17, 2020.

Immediate Actions:

- Client #11's materials were updated to glasses and glasses case for his eyeglasses care program.
- Client #5's verbal reinforcement was updated to match the step in the objective for his washing cup program.
- Client #7's bed making program was updated to have the verbal reinforcement match the step in the objective.

STEPS FOR POC:

1. When the Habilitation Plan Administrators are analyzing their program data for the month of February, they will review the programs to ensure that the materials match the program. The Habilitation Plan Administrator will then send an e-mail confirming that they have reviewed all their teaching programs and that the materials match the programs.
    - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
    - Completion Date: March 15, 2020
2. When the Habilitation Plan Administrators are analyzing their program review data for the month of February, they will review the reinforcements in the programs to ensure that they match the step in the

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current objective. The Habilitation Plan Administrators will then send an e-mail confirming that they have reviewed all their teaching programs and the reinforcement matches the step in the objective. ○ Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director ○ Completion Date: March 15, 2020
Monitoring Procedure for Implementing the POC:
1. The Developmental Disabilities Administrators will review all formal teaching programs during their program reviews for discrepancies. ○ Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

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Plan of Correction

DATE OF SOD
01/21/2020
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02/05/2020

CITATION

Citation: W239 Individual Program Plan

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to identify a replacement behavior for one of eight Sample Clients (Client #3). The facility changed the previous replacement behavior to a training program and did not identify a new replacement behavior and develop a program for it. This failure prevented Client #3 from receiving training on how to meet his needs in socially acceptable ways.

Facility Analysis of the Processes that led to the Deficiency:

- The facility had been working towards a system that would better identify Clients that would benefit more from a Mental Health Program versus a Positive Behavior Support Plan. This is a new system that is being developed by the facility therefore it is still in progress. In the new system, a Mental Health Plan template is being developed but has not been finalized.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is February 18, 2020.

Immediate Actions:

- Shortly after survey ended Client #3 returned to the hospital and was admitted. If Client #3 returns to the facility, the Interdisciplinary Team will assess to determine the appropriate plan for him upon readmission.

STEPS FOR POC:

1. The Psychologists will identify all Clients on their caseloads that they believe could benefit from a Mental Health Plan versus a Positive Behavior Support Plan. The Psychologist will then e-mail a list of these individuals to the Program Area Director.
    - Person Responsible: Psychologists with oversight by the Lead Psychologist
    - Completion Date: February 28, 2020
2. For the Clients that were identified to benefit from a Mental Health Plan versus a Positive Behavior Support Plan, their plans will be reviewed and if appropriate the process of updating to a Mental Health Plan will begin.
    - Person Responsible: Psychologists with oversight by the Lead Psychologist
    - Completion Date: March 20, 2020
3. As the plans are updated to Mental Health Plans for the identified Clients, the Psychologist will in-service the Direct Care Staff responsible for the Client prior to implementation.
    - Person Responsible: Psychologists with oversight by the Lead Psychologist
    - Completion Date: March 20, 2020

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4. Prior to the implementation of an updated Mental Health Plan for a Client, the Habilitation Plan Administrator will complete an Individual Habilitation Plan Revision will to address the change in the program.
    - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
    - Completion Date: March 20, 2020
5. The Psychologists will review all of the Positive Behavior Support Plans on their caseloads to ensure that all Positive Behavior Support Plans have appropriate functional replacement behaviors and there are detailed staff instructions in teaching clients to use their replacement behaviors to prevent the occurrence of the challenging behavior and how data is to be collected.
    - Person Responsible: Lead Psychologist with oversight by the Program Area Director
    - Completion Date: March 20, 2020

Monitoring Procedure for Implementing the POC:

1. During the clinical review of the Mental Health Plans, the Lead Psychologist will ensure that the treatment intervention training plans and data collection datasheets meet regulatory standards and have clear instructions for staff to provide the mental health treatment needed to help the individual cope appropriately.
    - Person Responsible: Lead Psychologist with oversight by the Program Area Director
2. While doing program reviews, the Lead Psychologist will ensure that Positive Behavior Support Plans have functional replacement behaviors that are clearly described in the Functional Assessment and include clear Positive Behavior Support Plan Staff Instructions on how to intervene and what they should be taking data on.
    - Person Responsible: Lead Psychologist with oversight by the Program Area Director

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Plan of Correction

DATE OF SOD
01/21/2020
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02/05/2020

CITATION

Citation: W250 Program Implementation

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to update Active Treatment Schedules to reflect current Individual Habilitation Plans (IHP) for three of eight Sample Clients (Clients #5, #6, and #8) and one Expanded Sample Client (Client #11). Client #6's Active Treatment Schedule was not updated to reflect his current prioritized needs. Clients #5, #6, #8, and #11's Active Treatment Schedules were not updated to reflect the addition of new training programs; or when those programs were to be implemented throughout the Clients' day. This prevented facility staff from knowing what, when, and where Clients' training plans were to be implemented.

Facility Analysis of the Processes that led to the Deficiency:

- While the facility was working on their plan to address the system for Active Treatment, there was significant fluctuation in Habilitation Plan Administrators. Three new Habilitation Plan Administrators were hired in October, one seasoned Habilitation Plan Administrator went out on unanticipated approved leave, one of the newly hired Habilitation Plan Administrators left at the end of November, and two new Habilitation Plan Administrators were hired on December 9, 2019. The Developmental Disabilities Administrators were covering caseloads for multiple units while training new Habilitation Plan Administrators. A new template for the Active Treatment Schedule was being developed in order to increase its' efficacy. The facility was under the impression that there would have been more time to finalize, implement, and train the on the new template prior to resurvey; however, due to an unexpected change in the survey timeline the entire process was not completed and some Active Treatment Schedules were not updated. While there were issues with the Active Treatment Schedules not being updated, it did not affect the implementation of the programs. The what, when, and where is also provided on the training programs, therefore, Direct Care Staff had another place to identify the information.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is January 27, 2020.

Immediate Actions:

- The new Active Treatment Schedule template was reviewed by the Program Area Director and Habilitation Plan Administrators were directed to update Active Treatment Schedules using the new template.

STEPS FOR POC:

1. The Habilitation Plan Administrators will be in-serviced on the content that must be included in the Active Treatment Schedules.

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- Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
- Completion Date: February 10, 2020

2. The Habilitation Plan Administrators will update all Active Treatment Schedules using the new template. As they are updated they will send them to their respective supervisor along with a list of all formal programs to be cross checked that all programs have been included in the schedule.
   - Person Responsible: Developmental Disabilities administrators with oversight by the Program Area Director
   - Completion Date: March 6, 2020
3. The Attendant Counselor Managers will be in-serviced on the new Active Treatment Schedule template.
   - Person Responsible: Program Area Director
   - Completion Date: February 19, 2020
4. The Habilitation Plan Administrator and Attendant Counselor Managers will in-service the Direct Care Staff on the updated Active Treatment Schedules as they are completed and prior to being implemented.
   - Person Responsible: Program Area Director
   - Completion Date: March 20, 2020
5. The Adult Training Specialists will be in-serviced on the updated Active Treatment Schedules as they are completed and prior to being implemented.
   - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
   - Completion Date: March 20, 2020
6. The Habilitation Plan Administrators will be in-serviced to include the Active Treatment Schedule with the Individual Habilitation Plan packet for review prior to implementation.
   - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
   - Completion Date: March 6, 2020

Monitoring Procedure for Implementing the POC:

1. The Developmental Disabilities Administrator will review the Active Treatment Schedule annually with the Individual Habilitation Plan program review.
   - Person Responsible: Program Area Director

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Plan of Correction

DATE OF SOD
01/21/2020
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02/05/2020

CITATION

Citation: W251 Program Implementation-Client #5

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to implement training program plans as written for two of eight Sample Clients (Clients #5 and #7). Staff did not implement the required standby assistance when Client #5 walked outdoors and Client #7's navigation program was not implemented when he left the house. This failure placed Client #5 at risk for falling while walking outdoors and Client #7 at risk for not being safe when he traveled outside his residence.

Facility Analysis of the Processes that led to the Deficiency:

- The Adult Training Specialist that was supervising Client #5 while ambulating outside the unit did not understand what standby assistance meant. The Direct Care Staff on Client #5's unit and Adult Training Specialists had never been specifically in-serviced on the varying levels of assistance that are indicated for the Clients, therefore, the Direct Care Staff and Adult Training Specialist were unable to accurately implement standby assistance.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is January 15, 2020.

Immediate Actions:

- The Direct Care Staff on Unit 305/306 and a portion of the Adult Training Specialists were immediately in-serviced on January 15, 2020 by the Physical Therapist to clarify what standby assistance is when working with Client #5.

STEPS FOR POC:

1. The Physical Therapist responsible for Client #5 will complete one observation a week for one month for Client #5 to ensure that his mobility assistance level is being implemented properly. If the Physical Therapist identifies any issues they will address them with the Direct Care Staff that is implementing incorrectly.
    - Person Responsible: Physical Therapist
    - Completion Date: March 20, 2020
2. The Physical Therapists will complete one observation a week for one month for a Client on their caseload to ensure their mobility assistance level is being implemented properly. If the Physical Therapist identifies any issues they will address them with the Direct Care Staff that is implementing incorrectly.
    - Person Responsible: Physical Therapists
    - Completion Date: March 20, 2020

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3. For those Clients identified with specific mobility needs, the Direct Care Staff for the corresponding unit were in-serviced on how to follow and implement the mobility assistance level identified in their program.
    - Person Responsible: Physical Therapists
    - Completion Date: February 4, 2020
4. There was a Mobility Assistance Level list developed that provided a brief description on how each Mobility Assistance level should be implemented. The Mobility Assistance Level list will be posted on both sides of the each unit so that Direct Care Staff have access to it.
    - Person Responsible: Attendant Counselor Managers with oversight by the Program Area Director
    - Completion Date: February 21, 2020

Monitoring Procedure for Implementing the POC:

1. The Physical Therapists will complete one observation a month for a Client on their caseload to ensure that their mobility assistance level is being implemented properly. If the Physical Therapist identifies any issues, they will address with the Direct Care Staff that is implementing incorrectly.
    - Person Responsible: Physical Therapists

Signature / Title

Date

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DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
FIRCREST RESIDENTIAL HABILITATION CENTER (RHC)

Plan of Correction

DATE OF SOD
01/21/2020
DATE OF POC
02/05/2020

CITATION

Citation: W251 Program Implementation-Client #7

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to implement training program plans as written for two of eight Sample Clients (Clients #5 and #7). Staff did not implement the required standby assistance when Client #5 walked outdoors and Client #7's navigation program was not implemented when he left the house. This failure placed Client #5 at risk for falling while walking outdoors and Client #7 at risk for not being safe when he traveled outside his residence.

Facility Analysis of the Processes that led to the Deficiency:

- The Direct Care Staff have been in-serviced on implementing programs at all opportunities throughout the day following our last survey. In attempt to make running programs at all opportunities more ingrained in the system, a formal program run during multiple times a day in different environments. The plan was then to fade the formal data being taken multiple times a day in different environments with Direct Care Staff incorporating the skill when opportunities were presented. Client #7's program specifically stated to run the "Safely Navigating Campus" both formally and as informal opportunities arise. This did not occur.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is February 14, 2020.

Immediate Actions:

- An in-service was started for Client #7's Direct Care Staff to ensure that teaching programs are run at all opportunities.

STEPS FOR POC:

1. The Habilitation Plan Administrator responsible for Client #7 will complete an observation of the "Safely Navigating Campus" program during a time when it is not supposed to be run formally to ensure that Direct Care Staff are implementing the program during all opportunities throughout the day. If there are identified issues, the Habilitation Plan Administrator will address them with the Direct Care Staff that is not implementing the program at all opportunities.
    - Person Responsible: Habilitation Plan Administrator
    - Completion Date: February 21, 2020
2. The Habilitation Plan Administrators will complete one observation a week for one month for a Client on their caseload to observe if the Client's formal programs are being run during all opportunities throughout the observation. If there are identified issues, the Habilitation Plan Administrators will address it with the Direct Care Staff that is not implementing the program at all opportunities.
    - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director

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- Completion Date: March 20, 2020

3. The Attendant Counselor Manager responsible for Client #7 will complete one observation of the "Safely Navigating Campus" program during a time when it is not supposed to be run formally to ensure that Direct Care Staff are implementing the program during all opportunities throughout the day. If there are identified issues, the Attendant Counselor Manager will address them with the Direct Care Staff that is not implementing the program at all opportunities.
    - Person Responsible: Attendant Counselor Manager
    - Completion Date: February 21, 2020
4. The Attendant Counselor Managers will complete one observation a week for one month for a Client on their caseload to observe if the Client's formal programs are being run during all opportunities throughout the observation. If there are identified issues, the Attendant Counselor Managers will address it with the Direct Care Staff that is not implement the program at all opportunities.
    - Person Responsible: Attendant Counselor Managers with oversight by the Program Area Director
    - Completion Date: March 20, 2020
5. When the Direct Care Staff are being in-serviced on the updated Active Treatment Schedules for their Clients, the Attendant Counselor Manager will include the expectation of formal programs being run at all opportunities throughout the Client's day.
    - Person Responsible: Attendant Counselor Manager with oversight by the Program Area Director
    - Completion Date: March 20, 2020

Monitoring Procedure for Implementing the POC:

1. The Habilitation Plan Administrators will complete one observation a month for a Client on their caseload to observe if the Client's formal programs are being run during all opportunities throughout the observation. If there are identified issues, the Habilitation Plan Administrators will address it with the Direct Care Staff that is not implementing the program at all opportunities.
    - Person Responsible: Habilitation Plan Administrators with oversight by the Program Area Director
2. The Attendant Counselor Managers will complete one observation a month for a Client on their caseload to observe if the Client's formal programs are being run during all opportunities throughout the observation. If there are identified issues, the Attendant Counselor Managers will address it with the Direct Care Staff that is not implement the program at all opportunities.
    - Person Responsible: Attendant Counselor Managers with oversight by the Program Area Director

Signature / Title

Date

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Plan of Correction

DATE OF SOD
01/21/2020
DATE OF POC
02/05/2020

CITATION

Citation: W252 Program Documentation

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to ensure staff documented data and/or comments to show they implemented programs or explained why a program was not implemented for three of eight Sample Clients (Client #2, #5, and #8). Staff did not collect data for a skill acquisition programs as required for Clients #2 and #5, and did not record a comment when a program was not implemented for Client #8. This prevented the facility from correctly analyzing the programs to determine if the facility needed to update or revise the programs to meet Clients' needs.

Facility Analysis of the Processes that led to the Deficiency:

- Following receiving this citation in the previous survey, the Program Area Team put in multiple layers of monitoring for data gaps to include Shift Charges during the night shift monitoring daily, the Attendant Counselor Managers reviewing the data weekly, and the Quality Assurance Department going out twice a month to review data gaps. While these monitoring tools have reduced the number of data gaps, they were still presenting during this survey. For Client #5, there was missing data due to the formal teaching plan missing from the program book. This was an error in communication between the Habilitation Plan Administrator and the Direct Care Staff. In the past, the Direct Care Staff have been in-serviced to provide a comment regarding why a program was not run and it is on the key for the formal teaching plans for Client #8. Even with data gap monitoring the missing comments were not identified and addressed. The Direct Care Staff did not follow facility expectations that data will be taken for Client programs. The Attendant Counselor Manager for Client #2 reviews all data gap information collected by the Shift Charge on Thursdays of every week. The teaching plans were reviewed by Residential Care Services prior to the review and therefore the plans had not been corrected and addressed with the staff involved. It appears that direct care staff are relying heavily on the review and corrections being made instead of thoroughly completing the documentation initially.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is February 12, 2020.

Immediate Actions:

- Identified documentation errors on the above mentioned programs were addressed.

STEPS FOR POC:

1. The daily data gap monitoring tool will be updated to review if there is a comment for the "Not Run" entries. If there is a missing comment for a "Not Run" entry will be identified and addressed with the Attendant Counselor Manager.
    - Person Responsible: Program Area Director
    - Completion Date: February 21, 2020

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2. The Attendant Counselor Managers will be in-serviced on the updated monitoring tool.
    - Person Responsible: Program Area Director
    - Completion Date: February 26, 2020
3. The Attendant Counselor Managers will address all identified data gaps.
    - Person Responsible: Attendant Counselor Managers with oversight by the Program Area Director
    - Completion Date: March 6, 2020
4. The Attendant Counselor-3s on night shift will be in-serviced on the updated monitoring tool.
    - Person Responsible: Attendant Counselor Managers with oversight by the Program Area Director
    - Completion Date: March 13, 2020

Monitoring Procedure for Implementing the POC:

1. The Quality Assurance Department will complete data gaps checks on all units twice a month. The results of the review will be sent to the Program Area Director, the Developmental Disabilities Administrators, and the Interdisciplinary Teams for any appropriate follow up necessary.
    - Person Responsible: Quality Assurance Director

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Plan of Correction

DATE OF SOD
01/21/2020
DATE OF POC
02/05/2020

CITATION

Citation: W352 Comprehensive Dental Diagnostic Service

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to ensure an annual dental assessment occurred for one of eight Sample Clients (Client #4). This failure put Client #4 at risk for unidentified dental concerns.

Facility Analysis of the Processes that led to the Deficiency:

- Client #4's file had an Annual Dental Assessment dated for 09/10/18; however, Client #4 had significant medical event happen in 2019 which kept him in the hospital for a significant period. Upon return to the facility, the IDT attempted to get the guardian to agree to sedation in order to complete his Annual Dental Assessment in 2019. Client #4 did have a recall exam on 05/09/19 which included a full cleaning and full mouth scaling. Client #4 had another appointment for a crown placement on 06/27/19. The notes for the follow up appointments on 05/09/19 and 06/27/19 are documented in the Physician Progress Notes in the Client file. The Annual Dental Assessments indicates how often the follow up examinations are completed. When asked, the difference between an Annual Dental Assessment and a recall examination the dentist stated that they are minimal differences between the two. She stated that one is put into the Annual Dental Assessment and the other goes into the Physician Progress Notes but they are all considered exams. It is possible that since the recall exams are not in the Client file in the same area as the Physician Progress Notes the surveyor did not see them and take the exams into consideration. The guardian did not consent to the new annual sedation consent when the Annual Dental Assessment was due therefore that appointment did not occur. The guardian did agree to dental sedation in January 2020 due to the need for an emergency extraction and the Annual Dental Assessment was completed during that appointment.

Plan for Correcting the Specific Deficiency:

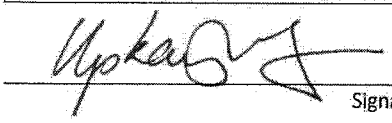
- This portion of the POC start date is January 15, 2020.

Immediate Actions:

- Client #4 had his Annual Dental Assessment completed on January 15, 2020 when he was sedated for the emergency extraction.

STEPS FOR POC:

1. Physician Progress Notes will be added to the dental section of the Client file for follow up appointments and dental related notes.
    - Person Responsible: Forms and Records Analyst-2
    - Completion Date: March 6, 2020
2. The dentist will be in-serviced to write her follow up appointment notes in the newly added Physician Progress Notes in the dental section of the Client file.



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- Person Responsible: Program Area Director
- Completion Date: February 21, 2020

3. The dentist will complete all examinations on an Annual Dental Assessment form.
   - Person Responsible: Dentist
   - Completion Date: March 20, 2020
4. The dentist will be in-serviced on using the Annual Dental Assessment form for all examinations.
   - Person Responsible: Superintendent
   - Completion Date: March 6, 2020

Monitoring Procedure for Implementing the POC:

1. The Developmental Disabilities Administrators will complete a random sample of Client file reviews to verify that the dental follow up exmanination information is being documented in the appropriate section of the Client File.
   - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

Signature / Title

Date

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FIRCREST RESIDENTIAL HABILITATION CENTER (RHC)

Plan of Correction

DATE OF SOD
01/21/2020
DATE OF POC
02/05/2020

CITATION

Citation: W407 Client Living Environment

- This standard is not met as evidenced by:

Based on record review and interview, the facility failed to assess and document the benefit of one Expanded Sample Client (Client #9), identified during the Recertification Survey completed 10/11/19, living with Clients that did not match his developmental and social abilities. This failure caused Client #9 to remain living with peers who had significantly different skills and abilities from his without justification by the facility.

Facility Analysis of the Processes that led to the Deficiency:

- Client #9 was asked following the original citation on whether he would like to move units. He stated it was his preference to stay on the unit that he currently resides. This was documented in the Individual Habilitation Plan; however, the explanation and reasoning did not adequately address the rationale for the living environment. Client #9 has been asked and informed of the benefits of living on other units that might fit his social needs more appropriately. Client #9 continues to state that he does not want to move units. Client #9's guardian remains adamant that Fircrest is the best place for him.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is February 21, 2020.

Immediate Actions:

- The team will meet to add a more thorough discussion into the Qualified Intellectual Disability Reviews in regards to Client #9 and his living environment.

STEPS FOR POC:

1. A meeting with Client #9 and guardian will be established to discuss the possibility of moving to a community placement. The Habilitation Plan Administrator will document the discussion.
    - Person Responsible: Habilitation Plan Administrator
    - Completion Date: March 6, 2020
2. The Habilitation Plan Administrators will be in-serviced on how to best document the rationale for the living environment.
    - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director
    - Completion Date: February 21, 2020

Monitoring Procedure for Implementing the POC:

1. The Developmental Disabilities Administrators will review living preferences during program reviews.
    - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

Superintendent — Signature / Title

2/21/2020 — Date

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Plan of Correction

DATE OF SOD
01/21/2020
DATE OF POC
02/05/2020

CITATION

Citation: W474 Meal Services

- This standard is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to provide the correct diet texture to one of eight Sample Clients (Client #2). Client #2 received a snack that was not in the Dysphagia Advanced (food cut into pieces no larger than ½ inch, and no dry, hard, or crunchy foods) texture as prescribed in his diet orders. This endangered Client #2's health and safety; such as choking or aspiration (when food or saliva enters the airway and lungs).

Facility Analysis of the Processes that led to the Deficiency:

- The Direct Care Staff admitted to not following Client #2's dining guidelines stating that he personally believes that he was being generous to the Clients that he has worked with for so long and built a relationship with. It is socially normal to use food in many ways to connect with each other or as coping mechanisms, i.e. to celebrate, alleviate stress, team build, grieve, etc. In this case there was a blurred line between work and social normalcy. The staff now recognizes the risks such things could have on a client and the importance of following assessed dining guidelines.

Plan for Correcting the Specific Deficiency:

- This portion of the POC start date is January 14, 2020.

Immediate Actions:

- The Direct Care Staff that did not follow the dining guidelines was in-serviced on following the dining guidelines for Client #2 as well as following dining guidelines for all Clients.
- The Attendant Counselor Managers began in-services to all Direct Care Staff on following dining guidelines for all Clients as written.

STEPS FOR POC:

1. The Speech-Language Pathologist responsible for Client #2 will complete one meal observation a week for one month to include a breakfast, lunch, and dinner observation. If there are any issues during the observations, the Speech-Language Pathologist will address them with the Direct Care Staff.
    - Person Responsible: Speech-Language Pathologist
    - Completion Date: March 11, 2020
2. The Speech-Language Pathologists will complete one meal observation a week for their caseload for one month to include a breakfast, lunch, and dinner observation. If there are any issues during the observations, the Speech-Language Pathologist will address them with the Direct Care Staff.
    - Person Responsible: Speech- Language Pathologists
    - Completion Date: March 11, 2020

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3. The Occupational Therapist responsible for Client #2 will complete one meal observation a week for one month to include a breakfast, lunch, and dinner observation. If there are any issues during the observations, the Occupational Therapist will address them with the Direct Care Staff.
    - Person Responsible: Occupational Therapist
    - Completion Date: March 11, 2020
4. The Occupational Therapists will complete one meal observation a week for one month to include a break, lunch, and dinner observation. If there are any issues during the observations, the Occupational Therapists will address them with the Direct Care Staff.
    - Person Responsible: Occupational Therapists
    - Completion Date: March 11, 2020

Monitoring Procedure for Implementing the POC:

1. The Speech-Language Pathologists will complete one observation per month for one Client on their caseload to ensure that the Client's dining guidelines are being implemented as written. If there are identified issues during the observation, the Speech-Language Pathologist will address it during the observation.
    - Person Responsible: Speech-Language Pathologists
2. The Occupational Therapists will complete one observation per month for one Client on their caseload to ensure that the Client's dining guidelines are being implemented as written. If there are identified issues during the observation, the Occupational Therapist will address it during the observation.
    - Person Responsible: Occupational Therapists
3. The Developmental Disabilities Administrators will be reviewing dining guidelines during their program reviews and will ensure that the dining guidelines are consistent throughout the Client's program.
    - Person Responsible: Developmental Disabilities Administrators with oversight by the Program Area Director

Signature / Title

Date